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THE GREAT FELLATIO DEBATE

HOW SAFE IS ORAL SEX?

BY MARK SCHOOFS

SCOTT MENCHIN

What men really want is not knowledge but certainty.
—Bertrand Russell

What are the chances of getting HIV through fellatio? This is probably the sexual question gay men ask most frequently, and it's one many straight women are asking as well.

But people cannot get a consistent answer. "One day you hear it's not a risk," says AIDS activist Spencer Cox, "and the next day you hear, Don't even think about putting your tongue on a cock." Cox is exaggerating only slightly. At the International Conference on AIDS this summer, Gay Men's Health Crisis sponsored a standing-room-only forum on the subject. Three scientists explained that although some people have been infected through oral sex such cases appear to be rare. Despite the widely ➤➤

➤➤ reported discovery that monkeys can easily be infected by swabbing the back of their tongues with SIV, the simian cousin of HIV, humans usually catch the AIDS virus sexually through anal or vaginal intercourse.

The panel's last speaker was gay activist and author Eric Rofes. "The oral sex panic," he declared, arises from "a deeply rooted anxiety about what we do with our bodies with other males" and from society's dismissal of "the authentic need that many men have to exchange semen." Rofes ended by exhorting the audience to "hold our ground" on oral sex. "If you want to make it even more safe, don't let him come in your mouth. But keep doing it!"

The very next day, researcher Timothy Schacker presented data on people newly infected with HIV. In 12 cases, Schacker had been able to identify the specific sexual episode that most likely transmitted the virus; in four cases, the riskiest activity was fellatio. In two, the men's partners confirmed their stories. Schacker concluded that "oral transmission of HIV may occur more often than previously recognized."

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To Schacker, a key finding was that the men in his study were having oral sex without a condom about 20 times more frequently than they were having unprotected receptive anal sex. So, although the risk for a single act of fellatio is much less than for anal sex, Schacker says, "if you perform oral sex enough times, your cumulative risk could be substantial."

Schacker's study is too small to be conclusive. But it documents something many clinicians and researchers have noticed: a persistent trickle of infections among people who say fellatio is their primary risk factor. Four out of 102 newly infected gay men in Amsterdam cited oral sex as their riskiest behavior, one out of 50 in Boston, three out of 49 in San Francisco, one out of 41 in a second S.F. study, and six out of 28 in Stockholm. In addition, at least a dozen more cases are in the scientific literature, and researchers in Sweden and New York are preparing to publish new reports of individuals getting infected through fellatio.

On the other hand, there is persuasive evidence that HIV is hard to catch through oral sex. Several studies of heterosexual couples, in which one partner was HIV-positive, found that none of the women who performed fellatio but used condoms for vaginal intercourse got infected. In a large American study, none of the 147 men who had oral but not anal sex got infected.

Case reports are also inconclusive. One man who contracted HIV through oral sex had performed fellatio on hundreds of partners a year, often to ejaculation, in San Francisco, the epicenter of the epidemic. Yet this man repeatedly tested HIV-negative until 1989, a bullet-dodging feat that would be virtually inconceivable had he been having that much anal sex. This suggests oral sex is "low risk," says Paul O'Malley, an official with the San Francisco Department of Health who helped document this case. But he points to another man infected through oral sex, who had fellatio with his HIV-positive boyfriend for only a few months.

These numbers may seem small, but "do you know how hard it is to become a case report?" asks O'Malley. Not even the Centers for Disease Control, which collects AIDS statistics, asks what sex act transmitted the virus.

The *Voice* faxed a survey to AIDS doctors across the country. Of the 40 who responded, 17 had patients who said they were infected through performing fellatio. The doctors "strongly believe" 61 of these patients. This represents only a sliver of the thousands of people with AIDS they have treated, but the total number is too substantial to dismiss.

Such stories are not uncommon in the gay community. Even Rofes, the activist who urged gay men to keep having oral sex, knows people—"including a friend"—who say they were infected via fellatio. Nevertheless, he believes the risk is "near negligible."

To resolve the contradictions that inevitably arise from small studies and anecdotal reports, people look to large epidemiological studies. In the U.S., most of these have been conducted among gay men. What's more, most major investigations of heterosexual transmission have taken place in Africa and Asia, where cultural mores can make it hard to track infections through fellatio. Ann Duerr, an AIDS researcher with the CDC, recalls that when she worked in Rwanda, "I couldn't even get my nurses to ask about oral sex. It was, 'Put what in your mouth?' " As a result, AIDS educators have skimpy data to pass on to their female clients.

Still, all major studies have found that fellatio is much safer than anal or vaginal sex. Unfortunately, they prove nothing else. "To say oral sex is low risk, and that people can engage in that activity over long periods of time without worrying about it, would be the wrong inference," says Victor DeGruttola, an AIDS statistician. Because of the difficulty of determining which sex acts transmitted the virus, the risk of oral sex "cannot be determined from a general epidemiological study," DeGruttola says.

Nowhere does this uncertainty show up more starkly than in risk estimates. At one extreme, oral sex was reckoned to be only 5.3 times safer than anal sex. But another estimate concludes that it is 100 times safer. The researchers who came up with these two figures—James Koopman and David Ostrow, respectively—told the *Voice* that they amounted to little more than back-of-the-envelope calculations.

Another calculation comes from a study involving almost 3000 men. Those who reported having no anal sex in the six months before their HIV test were about 32 times less likely to test positive than those who did. Lead researcher Roger Detels says this figure can serve as a rough gauge of fellatio's risk. Very rough indeed, because the margin of error is extremely wide: Men who avoided anal sex could have been anywhere from nine to 263 times safer.

Part of the difficulty is that infectiousness varies. People with AIDS can transmit the virus more easily in late-stage illness, and probably also in the first few months after they are infected. But during the intervening years, any STD or genital tract inflammation can dramatically increase the amount of HIV in semen. Similarly, uninfected people are probably more vulnerable to catching HIV when they are sick, and maybe even when they are just feeling run-down.

Risk estimates are for populations. But a person about to suck a particular penis needs to know the chances of infection then and there. "That has not been measured," says Richard Elovich, an AIDS educator at GMHC, "and really can't be."

How people have oral sex varies tremendously, and that can make all the difference.

"I drew the line at taking cum in my mouth," says Joey, who asked that his real name not be used. Joey's policy is common, and many gay men believe that by keeping semen out of their mouths they will keep HIV out of their bodies. Scientists agree that this reduces the chance of infection—if only because precum is a smaller amount of fluid than ejaculate—and in most documented cases where researchers asked, infected men had taken semen into their mouths. (On such occasions, many experts suggest spitting it out because swallowing can bring the virus into contact with cells along the

esophageal tract. Rinsing with mouthwash, peroxide, or hard liquor "would probably help," says a CDC spokesperson.) But other factors are also important.

At an all-weekend party, Joey took several drugs: Ecstasy, K, and cocaine. While high, he had sex with a guy he knows to be HIV-positive. During their two-hour liaison, they blew each other repeatedly and vigorously. "Between men," says Joey, "cocksucking is almost a competitive thing: Can you take the whole dick down your throat?" In doing that, Joey created "a shitload of friction" against the back of his throat.

Researchers believe deep-throating raises the risk of infection, even without ejaculation. In most people, the lining of the mouth probably has to tear for HIV infection to occur, according to London University researcher Thomas Lehner, and that is more likely to happen with rough oral sex.

In a study published last year, Lehner biopsied tissues from the mouth, vagina, rectum, and foreskin. He looked for the cells HIV is believed to infect during sexual transmission, called CD4+ Langerhans. He discovered that these vulnerable cells rarely lie near the surface of tissues that line the mouth, though they abound deeper down. By contrast, most of the foreskin and vaginal specimens showed a lot of Langerhans cells near the surface. "There is a possibility" that infection could occur in the mouth without tissues tearing, says Lehner, "but the chances are much lower" than with vaginal or rectal sex.

Deep-throating may carry extra risk, because the throat may be more susceptible to infection than the mouth. The tonsils are "anatomically adapted" to trapping incoming pathogens, says Sarah Frankel, an expert in this subject. Ejaculating or rubbing precum into the tonsils raises the danger. What's more, the nearby adenoid gland has a lining which contains Langerhans cells on its surface. And special "dendritic" cells deep in the tonsils and adenoids can hook HIV from the surface with long tendrils. Coming "on the front of the teeth is a whole different thing from ejaculating in the back of the throat," says Frankel. If friction during fellatio exposed any vulnerable cells, ejaculation may not be necessary for infection. Precum contains "quite a bit of virus," says Harvard's Deborah Anderson, an expert on HIV in genital fluids. Saliva can inhibit HIV, but recent research shows this varies greatly from person to person.

About three weeks after his episode of hot and heavy oral sex, Joey came down with flu-like symptoms, and blood tests verified that he was undergoing "conversion illness," the sign that a person is becoming HIV-positive.

The way Joey had oral sex is common among gay men, but not among women, says sex researcher Pepper Schwartz, who coauthored a study of 6000 gay, lesbian, and heterosexual couples. "Very few straight women will go beyond the gag reflex, but that is almost normative among gay men." Schwartz also found that gay men are "far more likely to swallow semen. Women basically don't like to swallow and don't do it most of the time." From her interviews, Schwartz concluded that only about 20 per cent of women consistently swallowed, whereas about 80 per cent of the gay men did.

Schwartz, who published her couples book in 1983, thinks many gay men may have modified their technique because of AIDS. A recent New York study confirms her hunch: Only 15 per cent of gay men took semen in the mouth. But the urge "is still there," as Schwartz attests. In the *Voice* survey, doctors with a mostly gay clientele were much more likely to have patients who were infected through fellatio.

Gay men are also at higher risk because they have, on average, more partners than straight women. Joey had two other sexual episodes in the month before his conversion illness. Both times, he was the one being sucked. (There are at least four case reports of men being infected by having their penises sucked. But that is not considered a high-risk activity because saliva contains much less HIV than semen.) From one of the men who sucked him off, Joey got gonorrhea, and it's possible that HIV piggybacked on that infection.

Finally, Joey might have had an oral infection during that fateful weekend. A study of more than 1100 HIV-negative gay men found that more than a quarter had gingivitis, or inflammation of the gums, which can facilitate infection. Dentists say that many people don't notice gingivitis. And all researchers suggest using condoms if people have just flossed or have any cuts or sores in the mouth.

Joey admits that "no one ever said oral sex was perfectly safe." But like a lot of people, he thought the risk was so remote that he "had a better chance of winning the lottery than picking up HIV from sucking dick." So when he first found out he was infected, he felt stunned.

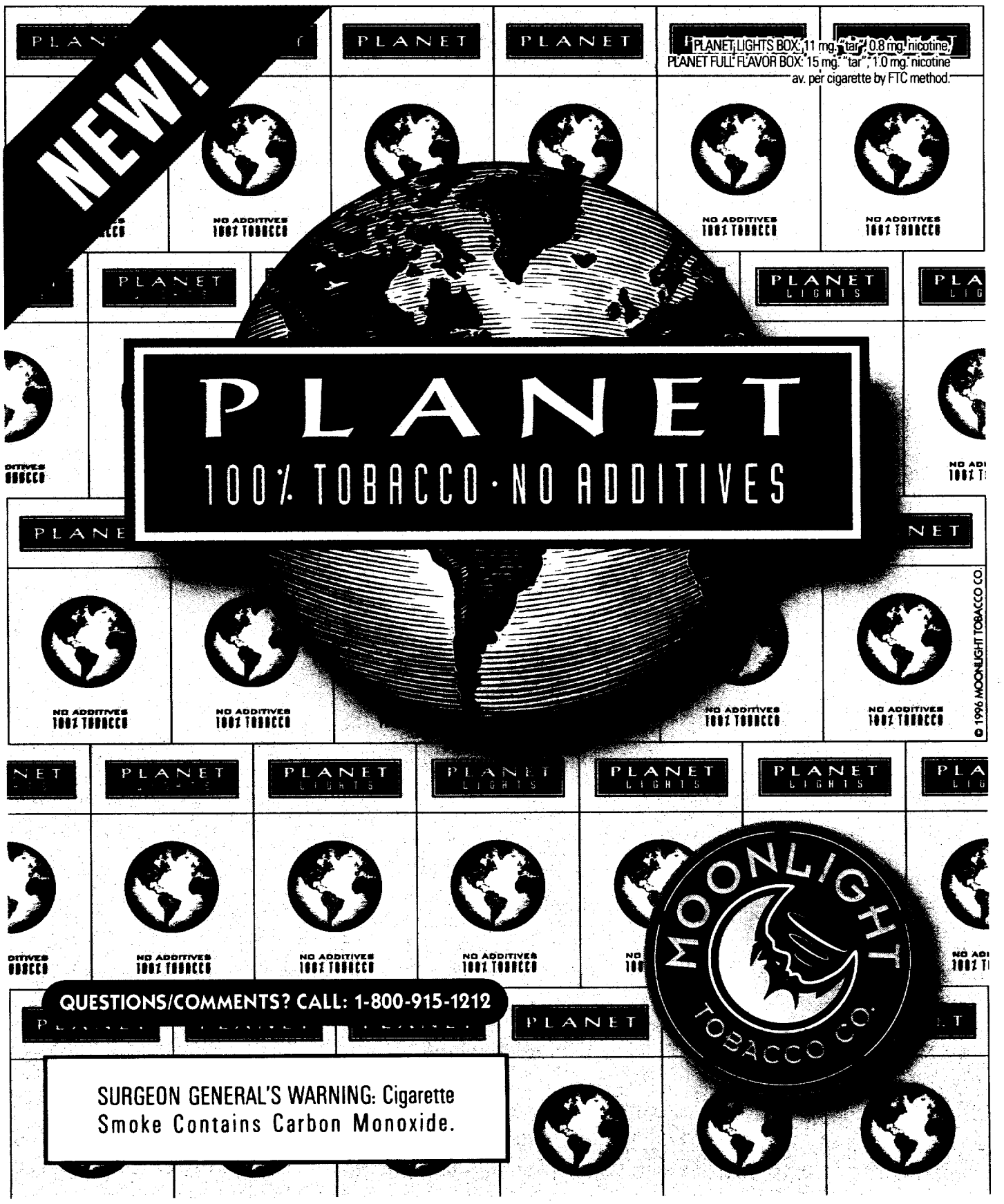
Why don't people use condoms? A few do. But of the 80 to 90 per cent of gay men who engage in fellatio, a mere 3 to 6 per cent rubber up their partners.

Less information exists for heterosexuals, but in one study, about three-quarters were having fellatio without condoms. More evidence comes from anecdote, which overwhelmingly indicates that people are going down on each other without protection. (There are a handful of documented cases of lesbians and men getting infected through cunnilingus; while it is conceivable, there is no recorded case of a woman catching HIV by having her vagina licked.)

Condoms prevent the sharing of semen, an act many find extraordinarily intimate and meaningful. They also desensitize the penis, sometimes so much that it goes limp. But for the receptive partner in anal or vaginal intercourse, a condom doesn't make much difference: Whether the penis is sheathed or not, the friction remains. In fellatio, however, friction isn't usually the turn-on. Smell and taste are what matters, and latex masks the musk. "You might as well not be doing it if you're not tasting skin," says author Erica Jong, who swears she would "never" use a rubber for fellatio.

For people who won't use condoms, there are ways to make fellatio safer. One way is to avoid having oral sex with strangers. This is a common strategy, according to AIDS educator Elovich, and if one's only partner is HIV-negative, it doesn't merely reduce the risk, it eliminates it.

Many gay men have already adopted this



arrangement for anal sex: They'll fellate tricks but save intercourse for their lover. In part, this is because blowjobs are ideal for quick or casual encounters. So for people who like anonymous sex—and for those whose lovers are HIV-positive—the discussion often turns to technique.

Many people avoid the head of the penis, licking only the shaft and testicles. This is the safest method, but people have developed less certain ones. In order to avoid preseminal fluid, some men suck the penis until it becomes fully erect, or for only a short time afterward. Others pull away as soon as they taste precum. Still others won't have oral sex if they have burned their mouth by, say, eating hot pizza.

By lowering the risk, these strategies can also lower one's angst. But they rarely eliminate it. "Over and over," says Elovich, "I hear people dealing with anxiety: 'I did this on Saturday night, and I felt depressed or freaked out on Sunday. I don't want to go through another depressed Sunday, or another three months waiting for my HIV test.' People learn to make better decisions through the pain of that anxiety."

Everyone's terrified," says Jong. Indeed, heterosexual transmission is the fastest growing risk category. In 1985, straight sex accounted for just 2 per cent of all U.S. AIDS cases; last year, that figure was 11 per cent and rising. Women get infected through heterosexual sex much more often than men, and AIDS is now the third leading cause of death among women between the ages of 25 and 44.

But the anxiety about oral sex is more intense among gay men. "Gay community forums on oral sex are jammed," notes AIDS prevention researcher Ron Stall. The Great Oral Sex Debate, as more than one activist calls it, has sparked acrimonious disputes among gay leaders, with accusations of "internalized homophobia" flying every which way.

The main reason for this intensity is obvious: AIDS has been raging among gay men for 15 years. But fellatio is also "a more central part of sex" for them than for heterosexuals, says Schwartz. She found that "gay men do it for more time, and more often to orgasm."

Of course, many women give blowjobs "with gusto and joy," as Jong puts it. "Fellatio is about devouring. It's very primal." But a surprising number of women don't like the act. According to *Sex in America*, based on the landmark survey of American sexual practices, more than four out of 10 women found giving head "not appealing" or "not at all appealing." Fewer than two in 10 found it "very appealing."

"The politics of gender inequality play into this," says Schwartz. For many women, fellatio "can be seen as subservient." But when there's a mutual relationship, Jong thinks many women get a "vicarious pleasure from being in control of a man's pleasure. It's very ego-enhancing for a woman to feel she's pleasuring her partner."

Several surveys affirm that fellatio is more cherished by gay men. "A lot of gay men don't like anal sex," says Schwartz, "so what do they have left?" That is even more true in the age of AIDS. Because condoms can break or leak, many gay men go without anal intercourse for long periods. For them, fellatio isn't just the

WHAT THE STATS DON'T SHOW

Why don't we know how risky oral sex is?

Consider the following case: Marcus Conant, a prominent San Francisco AIDS doctor, describes a patient who regularly engaged in fellatio. "He had only one guy screw him in his whole life. It hurt him so bad and he bled so much that he never did it again." When this patient tested positive, standard reporting procedures would have chalked his infection up to anal sex. But that would have masked the truth. "The man who screwed him was also my patient," explains Conant, "and he tested HIV-negative."

Few patients can trace their infection so accurately. Therefore, epidemiologists focus on populations to determine behaviors that correlate with contracting HIV. Unfortunately, statistical analysis is not very good at honing in on relatively low-risk factors such as oral sex.

For example, the California Deparment of Health has been interviewing everyone who receives state-funded HIV tests. Over a recent 18-month period, 2817 tests were given to gay or bisexual men who reported oral sex as their only risky behavior, ever. Forty-six of these tests—or about 1.5 per cent—came back HIV-positive. But when the data were churned through a statistical program to rank risk factors, fellatio correlated with *not* getting infected.

How did this happen? First, men who did not have oral sex were more likely to get infected, probably because they were having anal sex. Then, too, the California data was collected by more than 800 counselors who interviewed more than a quarter-million subjects. In such a mammoth and error-prone database, relatively low-risk activities such as fellatio don't break through. But, in a catch-22, more rigorous studies lack sufficient numbers to generate precise risk estimates for oral sex.

How much oral transmission could go undetected? Using a computer simulation, a graduate student of epidemiologist James Koopman showed that under certain circumstances oral sex would not register as statistically significant even if it accounted for 30 per cent of infections among gay men. Most researchers find this figure wildly exagerated, but Koopman believes it could be the actual rate of oral transmission.

His reasoning is based on a phenomenon known as "selective mixing." Large studies assume that HIV is distributed randomly in the population and that people select their sexual partners randomly. Both assumptions are false. In epidemiological terms, HIV is more prevalent in some "networks" than in others, and people mate selectively. "You can fall in love with someone across a crowded room," explains sex researcher John Gagnon. "But you have to be in the same room."

Selective mixing can hide the true risk of fellatio. For example, Koopman believes that men who only have oral sex are likely to select partners who also prefer that act (if only because men who like anal sex will want partners who can satisfy that desire). Dedicated fellators end up with partners less likely to be infected, because these partners are less likely to engage in anal sex. But that doesn't mean performing fellatio on an infected partner is safe.

Still, only one study has found a statistically significant risk to oral sex. The researchers later estimated that fellatio was between one-sixth and one-tenth as risky as anal sex. The study's principal investigator, Michael Samuel, acknowledges its limitations. The number of men who became infected was small, which could skew the results. Also, anal intercourse was excluded from Samuel's analysis; when it is added back in, oral sex loses its statistical significance.

Finally, there's the possibility that some of Samuel's study subjects lied about not having anal sex. "It's important to balance my study with the rest of the literature," Samuel says. (Indeed, another study tried to replicate his findings but couldn't.)

So what can be gleaned from this murk? "There is mounting epidemiological evidence for a small risk attached to orogenital sex," one survey of the scientific literature concludes. But that merely restates the question: Just how "small" is the risk? "The only thing you could infer," says AIDS statistician Victor DeGruttola, "is that we have to do a different kind of study." —M.S.

biggest risk they take, it's the *only* risk.

Still, the average gay man knows that fellatio is threatened, but by a risk that is uncertain and therefore all the more unsettling. "Because the risk is hard to define," says Elovich, "oral sex has become the site of our enormous anxiety about having sex when we're living through the AIDS epidemic."

Finally, there's homophobia, which has left many gay men deeply suspicious of any limitations imposed on their sexuality. In his book *Reviving the Tribe*, Rofes writes, "Many gay men hear a subtle but familiar message from safe sex campaigns: The meanings gay men find in their sexual congresses are spurious, trivial, or expendable." In such a climate, says Rofes, "I want to let people know that oral sex and all sex can be good."

Martin Delaney, one of the epidemic's leading activists, worries that gay leaders such as Rofes have launched "a political response to a medical problem. I think they've got it backwards." But the fact that many gay men believe homophobia lurks in the heart of AIDS education has made a scientific discussion of fellatio vastly more difficult.

Koopman remembers presenting a poster at the 1988 international AIDS conference suggesting that oral sex might be risky. Activists zapped his presentation, chanting "Sucking is safe!" That protest, says Koopman "is one of the reasons I haven't pursued" the investigation. At the GMHC forum, Ostrow lambasted journalists for publicizing scientific evidence suggesting fellatio might pose a significant danger. To deny that fellatio has "a value and meaning that could outweigh the risks," Ostrow later told the *Voice*, is "sex-negative."

"It bothers me," counters activist Delaney, "that we as gay men seem to equate our entire nature with sexual acts." A fulfilling sex life is valuable, he says, "but living a long and productive life is pretty important. And it's a pretty powerful political act as well."

In the midst of this psycho-political storm, pulled by anxiety and desire, gay organizations are redefining the risk of fellatio.

"Oral Sex *Is* Safer Sex," proclaims a poster recently wheat-pasted around New York by the grassroots AIDS Prevention Action League. The poster, which lists ways to make fellatio "even safer," reflects an ongoing shift in AIDS prevention policy. The dominant message used to be, "If there's any risk at all, don't do it," says Ilan Meyer, a member of APAL and an assistant professor of public health at Columbia Univeristy. The poster, he says, defines a "gradation of risk." And, he adds, it "counters the sexphobic advice that says, 'Just say no,' " by emphasizing that "not all homosexual sex is risky."

But activist David Gold is worried about applying terms such as *safer* and *low risk* to oral sex because he believes they are dangerously vague. "They fit with what everyone wants to hear," Gold says. "Negatives will hear that it's safe to suck, and positives will hear that they don't need to worry about infecting their partners, or about disclosing their status before they let someone suck them." Joey agrees: "Before I got infected, *safe* and *safer* sounded very similar. Now, having this virus in my body, the gap between them seems a lot wider."

GMHC has all but erased the gap. A recently published research summary—which Meyer coauthored—concludes: "oral sex offers a possible, but very low, risk of HIV infection. Unprotected oral sex is classifiable as *safer sex* or as *safe compared to safest. (Safest* can refer to completely non-insertive forms of sex, such as masturbation and frottage.)" The report then adds, "Avoiding ejaculation in the mouth . . . can lower risk of HIV transmission—and risk for other sexually transmitted diseases—even further." The clear implication is that, even with ejaculate in the mouth, oral sex is "very low risk" and "safe as opposed to safest."

GMHC has company. The Gay and Lesbian Medical Association recently released a report concluding that oral sex is "low risk." And at the forum in Vancouver, representatives from Canada and Germany scolded American AIDS organizations for having toed such a conservative line for so long on oral sex. But, as Gold and others point out, the stakes of being wrong are much lower in those countries. In Germany, the epidemic peaks in Berlin, where a mere 8 per cent of gay men are estimated to be HIV-positive. In Canada's hardest-hit city, Vancouver, roughly 25 per cent of gay men are believed to be infected. That's far less than the 40 to 50 per cent believed to be infected in San Francisco and Manhattan.

"As a positive person," says Tom Coates, a leading prevention expert, who objects to the GMHC report, "I can't imagine doing anything to infect other people."

Because of its worldwide stature, GMHC's report carries extra weight—and of course the agency provides it to men who come to its safer-sex workshops. This worries Delaney. "How does a 20-year-old kid respond to 'safe as opposed to safest?' " he asks. "It's perfectly okay to say the risk of oral sex is less than anal sex. But to use the word *safe* associated with any of this is really misleading."

GMHC associate executive director Mike Isbell defends the report. "For years we gave a red light on oral sex, and gay men ignored it," he explains. Trying to learn from that experience, GMHC is trying to treat gay men "as adults" by providing "more-nuanced information." Delaney isn't convinced: "If drug companies gave us data as soft as this, we'd sure scream."

But other AIDS experts insist that overstating the danger of oral sex, or "erring on the side of caution," might actually cost lives. Ostrow argues that "glorifying" fellatio can help men redirect their desire for "unprotected, uninhibited, mucous-membrane contact" away from anal sex. AIDS has left many gay men feeling fatalistic. They wonder when, not if, they will get infected. Asserting that oral sex is very low risk might throw them a lifeline of hope. Ostrow acknowledges that this educational philosophy would result in some infections, but he believes it would prevent a greater number.

Stall bristles at the "paternalism" of this approach. "We just have to give the best answers science can yield," he says, "and let people choose for themselves." Delaney worries about something more sinister: "You wonder if future evidence showed a clearer picture of increased risk of oral sex, would they be willing to change their views or have they dug in? Have people made this such a political issue that they won't change?"

AIDS activism has pushed for better research into every aspect of the epidemic, and "this question should not be allowed to fester in uncertainty for another decade," says Delaney. Adds Gold, "Someone should put together a blue-ribbon panel of scientists and community people, and have them design a study. This is so important to so many people's lives. They deserve answers." ❖

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